

FILED JAN 12 1944

Registration District No. 818

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County St Charles  
(b) City or town St Charles  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Josephine Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 30 mins  
(Specify whether  
In this community 7 hrs  
years, months or days)

3. (a) PRINT FULL NAME

J. W. Farris

3. (b) If veteran name war No

3. (c) Social Security No.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Almeda 6. (c) Age of husband or wife if alive 34 years  
7. Birth date of deceased May 16 1905  
(Month) (Day) (Year)

8. AGE: Years 38 Months 7 Days 14 If less than one day  
.....hr. ....min.

9. Birthplace Benton Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Mechanic

11. Industry or business

MOTHER FATHER

12. Name Unknown  
13. Birthplace Unknown  
14. Maiden name Unknown  
15. Birthplace Unknown

16. (a) Informant Almeda Farris

(b) Address 3658 Lafayette

17. (a) Removed (Burial, cremation, or removal) (b) Date thereof Jan 2 1944  
(Month) (Day) (Year)

(c) Place: burial or cremation Chaltee Mo

18. (a) Signature of funeral director Biophilus Funeral Home

(b) Address Chaltee Mo

19. (a) DEC 31 1943 (Date received local registrar) J. P. Boyce (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Charles  
(c) City or town Rural  
(If outside city or town limits, write "RURAL" and location)  
(d) Street No. Rural  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 30 1943  
year hour 6 minute PM

21. I hereby certify that I attended the deceased from Dec 28 1943  
to Dec 30 1943  
that I last saw him alive on Dec 30 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Diabetic Coma Duration History 2 1/2 yrs  
Due to Diabetes Mellitus

Due to GI  
Other conditions Cold  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings: No.  
Of operations No.  
Of autopsy No.  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: No  
(a) Accident, suicide, or homicide (specify) No  
(b) Date of occurrence None  
(c) Where did injury occur? None  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
No.  
While at work? No (Specify type of place) (e) Means of injury None  
23. Signature J. A. O'Brien (M. D. or other)  
Add: 208-1657 So Grand Blvd Date signed 12-31-43

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed..... *Howard A Rowland*.....

Licensed Embalmer No. *3114*.....

P. O. Address..... *St Louis, Mo*.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**